VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

June 30, 2015

Ms. Leslie Slingerland, Manager
Second Spring North
1071 Vt Route 15
Underhill, VT 05489-9341

Dear Ms. Slingerland:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 4, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 06/15/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0611	A. BUILDING: _____ B. WING _____	C 06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND SPRING NORTH	1071 VT ROUTE 15 UNDERHILL, VT 05489

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site investigation of a facility self-report was conducted by the Division of Licensing and Protection on 6/3/15 and 6/4/15. The following regulatory violations were identified.	R100		
R136 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the home failed to assure that assessments were conducted on an annual basis for 1 of 3 residents reviewed. (Resident #2). Findings include: Per record review there was no evidence of any reassessment, including annual assessment, in accordance with the requirements, of Resident #2, who was admitted to the home on 2/27/14. During interview, on the afternoon of 6/3/15, the RN Nurse Manager confirmed that there had been no further assessment of Resident #2, following his/her admission and prior to his/her discharge from the home on 4/8/15.	R136	See Attached 8/10/15	
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management	R162		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Program Admin. — (X6) DATE: 6/23/15

STATE FORM 6899 C2Q511 If continuation sheet 1 of 4

R136-R189 POC accepted 6/29/15 RHowe RN/pmc

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R162	Continued From page 1 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the home failed to assure that medications were administered in accordance with physician orders for 1 of 3 residents reviewed. (Resident #1). Findings include: Per record review Resident #1's MAR (Medication Administration Record) indicated that between the period of March 1, 2015 and March 19, 2015 the resident had received medications, for which there was no evidence of physician orders, on a daily basis, that included; Clozapine (an antipsychotic); Amlodipine (antihypertensive) and Meloxicam (pain reliever). The MAR revealed that the resident had received 100 mg of Clozapine by mouth every evening between March 1 and 19, 2015. A Medication Alert, completed by an RN (Registered Nurse) and dated 3/19/15, revealed there had been a new medication order that included; "Increase Clozapine to 125 mg by mouth at bedtime for one week, then to 150 mg by mouth at bedtime." The MAR further demonstrated that Resident #1 received 100 mg of Clozapine as well as 125 mg of Clozapine on the evenings of March 20 and 21, 2015, indicating that a total dose of 225 mg had been administered to the resident on each of those nights. During individual interviews on the afternoon of 6/3/15, both the RN and the unlicensed med delegated staff member responsible for the administration of Clozapine on	R162	See Attached 7/24/15	

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R162	Continued From page 2 3/20/15 and 3/21/15 respectively, stated they had each made a documentation error on the MAR, rather than an error in the dose of Clozapine administered, and both believed they had each administered a dose of only 125 mg and not 225 mg of Clozapine. In addition staff were not able to provide any physician orders for Resident #1 who had resided at the home from 6/3/14 through 3/24/15. The home's Program Director confirmed, during interview on the morning of 6/4/15, the lack of physician orders for Resident #1, and stated the orders had evidently been displaced after the resident's discharge from the home on 3/24/15.	R162	See Attached 7/24/15	
R189 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the home failed to assure that the record included documentation of all physician orders for 1 of 3 residents reviewed. (Resident #1). Findings include:	R189		

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R189	Continued From page 3 Per review Resident #1's record did not include documentation of any physician orders for the period of time from his/her admission on 6/3/14 through 3/24/15. Per review of the MAR (Medication Administration Record) for the dates from 3/1/15 though 3/20/15 staff had administered medications to the resident, on a daily basis, that included; Clozapine (an antipsychotic); Amlodipine (antihypertensive) and Meloxicam (pain reliever). However, there was no evidence of any physician orders for the medications. During interview, on the morning of 6/4/15, the home's Program Director confirmed the lack of physician orders and stated they had evidently been displaced at the time of the resident's discharge on 3/24/14.	R189	See Attached 7/24/15	

Plan of Correction

6-23-15

5.7 Assessment: 5.7c *Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition.*

Immediate: This was addressed in the moment. A yearly assessment for the individual was completed by the end of the day.

Ongoing: This is being addressed by educating nurses on the L and P policies regarding assessments and was **completed on 6/10** during nursing supervision.

We will also provide training yearly and upon hire.

5.10 Medication Management: 5.10c *Staff will not assist with or administer any medication, prescription or over-the -counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record.* And 5.12b *For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care.*

Immediate: The missing Physician's orders were located, obtained and re-united with the rest of the chart.

Ongoing: Re-Education was/is being provided to the nursing staff about documentation expectations and a review of how to transcribe doctor's orders correctly.

All staff involved with the incident will be met with and given at least a verbal warning. This has been mostly completed; one of the nurses involved is on vacation the meeting will be held when they return **(by 7/24)**.

We will also provide training yearly and upon hire.

Nurse Manager: Maryjane Corgnati Program Administrator: Leslie Slingerland

Maryjane Corgnati, RN Leslie Slingerland, BA

Date: 6-23-15 Date: 6-23-15